# GEORGIA CHILD FATALITY REVIEW PANEL

## Annual Report
## Calendar Year 2002

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This past year has been one of reflection and introspection. As we examined the efforts of the Panel and child fatality committees across Georgia to safeguard children, our attention was drawn to the long road ahead. But just as importantly, we looked behind us to see the long road already traveled. During the earlier years of child fatality review, many counties refused to review child deaths, basing their refusal on the law being an "unfunded" mandate. Others did not view the process as having a meaningful purpose; therefore their reviews were cursory at best. Compliance rates for reviews statewide were initially low with only 46.5% of eligible deaths being reviewed by counties in 1993.

Over the last ten years, we've seen a slow, but steady increase in the compliance rate. We've learned that child fatality review is a process, and to prevent child deaths, we must purposefully lay the groundwork necessary to achieve the desired goals for each stage of the process. County child fatality review committees must be educated on child deaths in their communities and the state. Training must be provided on conducting structured reviews and ascribing to proven prevention strategies. But most importantly, committees must embrace the idea of being gatekeepers to assure these prevention strategies are implemented in their communities. It is only then that we will begin to see the number of preventable child deaths decline.

The exciting news is that though child fatality review in Georgia has been a work in progress, committees are beginning to act on lessons learned. Many strides have been made at both the State and local levels to facilitate the implementation of practices to reduce the number of preventable child deaths. Staff members have worked hard with local committees to increase the rate of compliance for child deaths reviewed, and we are pleased that in 2002, 88% of child deaths eligible for review (528 of 601) were reviewed by local committees. This represented the highest compliance rate since the inception of child fatality review in Georgia. Examples of local committees' involvement in prevention efforts included:

- Work with a local hotel chain to offer cribs free of charge to parents with infants;
- Collaboration with the media to broadcast and print prevention information to benefit caretakers; and,
- A school system engaging students' help in recognizing and reporting possible signs of suicide observed in classmates and/or friends;
- Another school system provides parents with seasonal/age appropriate injury prevention tips with each (k-12) student's report card and/or progress report.

While realizing that we still have a ways to go in preventing child deaths, we are encouraged that Georgia is well on its' way, and committed to stay the course.

*In the words of Former Attorney General, Janet Reno, "We may not be able to save the life of every child, but we can try."*

# EXECUTIVE SUMMARY

The Georgia Child Fatality Review Panel (Panel) publishes an annual report chronicling the tragic, preventable deaths of children in Georgia. Information in this report details deaths that were sudden, unexplained and/or unexpected. This information is compiled from reports submitted by local child fatality review (CFR) committees. The Panel is charged with tracking the numbers and causes of child deaths as well as identifying and recommending prevention strategies that could reduce the number of child deaths.

## Key Findings

In 2002, 1,795 children died in Georgia. Based on death certificate data, 601 deaths were eligible for review. Child fatality review committees reviewed 528 of those deaths; however, the cause of death listed on death certificates and the cause of death determined by the child fatality review committees sometimes differed.

### FATAL CHILD ABUSE/NEGLECT

Department of Family and Children Services (DFCS) reported that 51 children in Georgia died as a result of substantiated abuse or neglect. Those deaths were investigated by DFCS, and did not include deaths handled by law enforcement and the courts without DFCS involvement.

**Child fatality review committees** determined that 63 child deaths resulted from confirmed abuse/neglect, and 47 child deaths resulted from suspected abuse/neglect. Perpetrators were identified in 65 of the 110 abuse/neglect related deaths, with 50 reviews also indicating the relationship of the perpetrator to the child. Fifty-six percent (56%) of those perpetrators were natural parents. Homicide was the cause of 28 confirmed abuse deaths, and children under the age of 5 accounted for 86% (24) of those homicides.

### NATURAL

**Death certificate data** indicated a total of 1,351 children under the age of 18 died of natural causes (including SIDS). Infants accounted for the vast majority (1,124) of those deaths. The leading causes of infant deaths continued to be congenital anomalies, low birth weight, and prematurity. There were 141 SIDS deaths, which was a 22% increase from the previous year.

**Child fatality review committees** reviewed 264 deaths from natural causes. One hundred fifty-two (152) of those deaths were SIDS/SUID. (SUID - Sudden Unexplained Infant Death - is a term used for a death that appears to be SIDS, but has other factors that *could* have contributed to the death.) Committees are required to review all SIDS deaths, and medical deaths that are unexpected or unattended by a physician.

### INJURIES

Death certificate data listed 416 deaths to have resulted from known injuries, but 7 of those deaths listed an unknown intent. An additional 28 deaths listed an unknown cause.

### UNINTENTIONAL INJURIES

**Death certificate data** indicated that 61% (372) of deaths in children ages 1 – 17 resulted from injuries (infant deaths [1,188], were mostly due to natural causes [1,124]). Seventy-eight percent (78%) of all injuries in the 1-17 year age group resulting in death were unintentional. The 3 leading causes of unintentional injury related deaths in all age groups included:

- 192 motor vehicle incidents
- 44 drowning incidents
- 22 fire/burn-related incidents

There was a decrease in the number of all deaths caused by unintentional injuries with the exceptions of drowning deaths (10% increase from 2001), and poisoning deaths (remained the same from the previous year). The most marked decrease in deaths from 2001 was suffocation (39%).

**Child fatality review committees** reviewed 287 deaths determined to have resulted from unintentional injuries. Child fatality review and death certificate data agreed on the 3 leading causes of death related to unintentional injuries (see above).

## INTENTIONAL INJURIES

**Death certificate data** indicated 83 children died from injuries intentionally inflicted by themselves or by others (suicide and homicide). In 2002, there were 58 homicides (a 22% decrease from 2001), and 25 suicides (a 36% decrease).
(*Note: The cause and/or intent of 35 child deaths were listed as undetermined on death certificates.)*

**Child fatality review committees** reviewed 89 deaths from intentional causes – 64 homicides and 25 suicides. Committees determined additional deaths to have resulted from homicide that were not identified as such on death certificates.

## FIREARM DEATHS

**Death certificate data** indicated firearms were used in 58 child deaths. Thirty-three of those deaths were ruled homicides, 15 suicides, and 9 unintentional. The intent of 1 firearm death was not determined.

**Child fatality review committees** reviewed 58 firearm related deaths. Eighty-three percent (83%) were intentional (34 homicides and 14 suicides). The type of firearm was identified in 52 of the 58 reviewed firearm related deaths. Handguns were most frequently used (42 of the 52 deaths where type of firearm was identified).

## PREVENTABILITY

A primary function of the child fatality review process is to identify those deaths believed to be preventable. The issue of preventability was addressed in 648 of the 655 child deaths reviewed. Child fatality review committees determined that 77% (501) of the 648 identified child deaths were definitely or possibly preventable. Ninety-seven percent (97%) of all reviewed child abuse/neglect deaths were determined to be definitely or possibly preventable.

## Agency Involvement/Intervention

**Child fatality review committees** reported that in 76 (69%) child abuse/neglect related deaths, the child and/or family had prior involvement with at least one state or local agency. Committees identified 5 instances in which agency intervention could have prevented child abuse/neglect related deaths.

Georgia Child Fatality Review Panel

*"Branching out for Prevention"*

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